



Please feel the followings:

First name

Last name

E-mail

Address

Location / City

Country

Phone

Mobile phone

BMI

Have you ever performed a surgical operation?

Yes, which and when?

No

Do you smoke?

Yes

No

Are you pregnant?

Yes

No

Do you have a history of medical diseases?

Hypertension

Pulmonary

Cardiac

Diabetes

Deep vein thrombosis or pulmonary embolism

Do you have allergies?

Yes and which?

No

Do you take pharmacy pills, vitamins or birth control pills?

Yes and which?

No

How did you learn about us?

Media (Newspapers, magazines, internet)

Our website

Television

Referral

PATIENT INFORMED CONSENT

1. I voluntarily request Plastic Surgeon IOANNIS LIAPAKIS and the associates, technical assistants, and other health care providers he may deem necessary to assist him in the surgical procedure below mentioned to treat my condition. The procedure has been explained to me as

2. I understand that during operation, Surgeons could discover other or different conditions, which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistant and other health care providers to perform other procedures that are advisable in their professional judgment.

3. I understand that no warranty or guarantee has been made to me as to result or cure. Realistic expectations are about 75% improvements. Some patients have great improvement and some have less improvement.

4. You must be aware that, although very low in this case, there are some risks and hazards involved in the performance of this surgical procedure which are infection, allergic reactions, bruising, bleeding, hematoma, poor healing, keloid formation. In very rare and extreme cases, death can occur. All possible alternatives for treatment with advantages and disadvantages have been explained to me in detail.

5. I have also discussed with the surgeon all the common risks/complications of the operation.

6. The following have also been carried out:

- I have met the Surgeon.
- I have discussed the technique the Surgeon will use for my operation.
- I know how long the operation is going to take.
- I know the cost of the operation and mode of payment.
- I know when I can return to normal activity after operation.

7. Dizziness may occur during the first week following surgery, particularly upon rising from a lying or sitting position. If this occurs, extreme caution must be exercised while standing. Someone must be present when you shower during the early post-operative period. Do not attempt to walk if dizziness is present.

8. I understand that secondary revisions or additional surgeries may be required in some cases. The cost of any of these additional surgeries varies from zero to one-half the original surgeon's fee. I understand that I will also be required to pay the additional anesthesia and operating room fees.

9. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the operation or procedures nor are there any guarantees against an unfavorable result. I acknowledge that you will do your best for me but I also recognize that you lack infallibility and those mistakes and accidents can occur in medicine as they can in any discipline. In the absence of a deliberate, premeditated act of negligence, I will not sue you.

10. I agree to be photographed before and after the procedure. The purpose of these photographs is for scientific and medical study and they belong to Dr IOANNIS LIAPAKIS. I agree to these photographs being published in doctor's medical articles, books or sites.

11. If I am a smoker, I accept the risk of respiratory complications and delayed wound healing resulting from the habit. I am informed that surgery is not recommended for heavy smokers.

12. I have received a thorough explanation of my preoperative and postoperative instructions. I understand these instructions and have received copies for reference. I understand that should I have any questions about the preoperative or postoperative instructions I should not hesitate to call. I acknowledge my obligation to follow these instructions closely and to visit the clinic for follow up care and instructions on postoperative day.

I certify that I have read the above consent and I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. I have received no medication before signing this consent. I hereby consent to surgery. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

_____ Patient Name

_____ Patient signature - Date